

Kentucky Boxing and Wrestling Authority
500 Mero Street, CPT 5th Floor, Frankfort, KY 40601
Fax: 502-696-3938

Medical release to return to competition following an injury
Physician's office must fax or mail this form to KBWA office

DATE OF EXAM _____

NAME _____

LAST FIRST MIDDLE

CURRENT ADDRESS _____

TELEPHONE # _____ DATE OF BIRTH _____ DATE OF INJURY _____

Being examined for the following injury/illness: _____
(Injury/illness and body part/area affected)

Following examination, it is my medical opinion that he or she:

_____ Is unable to return to competition until further notice.

Return appointment scheduled for _____
(Date)

_____ May return to training on _____
(Date)

_____ May return to full participation of Boxing/Wrestling/MMA on _____
(Date)

Restrictions, rehabilitation, treatment: _____

I attest that I do not have a professional relationship with, nor financial interest in the earnings of this individual.

(PRINT NAME OF EXAMINING PHYSICIAN)

(PHYSICIAN'S LICENSE NUMBER)

(SIGNATURE OF EXAMINING PHYSICIAN)

(ADDRESS OF PHYSICIAN)

(TELEPHONE NUMBER OF PHYSICIAN)

OFFICE STAMP